GENERAL INFORMATION

Any person or company may participate as an AHCCCS provider if the person or company is qualified to render a covered service and complies with AHCCCS policies and procedures for provider participation. Out-of-state providers also must register to be reimbursed for covered services provided to AHCCCS and ALTCS recipients.

Providers are required to:

- ☑ Complete an application,
- ☑ Sign a provider agreement,
- ☑ Sign all applicable forms, and
- ☑ Submit documentation of their applicable licenses and/or certificates

Information may be obtained by calling the AHCCCS Provider Registration Unit at:

Phoenix area: (602) 417-7670 (Option 5)

In-state: 1-800-794-6862 (Option 5)

Out of state: 1-800-523-0231, Ext. 77670

AHCCCS Provider Registration materials are available on the AHCCCS Web site at www.ahcccs.state.az.us. Click on the Information for Providers link on the AHCCCS home page. On the Provider page, scroll down to the Provider Registration section. All documents are in PDF format. They must be printed and completed offline.

When a provider's application is approved, an AHCCCS ID number is assigned, and the provider is notified by letter.

Certain out-of-state providers may qualify for a one-time waiver of full registration requirements. A provider who qualifies for this waiver must complete a Provider Agreement and a Form W-9: Request for Taxpayer Identification Number and Certification. The provider also must submit a copy of the provider's claim. A Medicare-certified facility also must submit a copy of its license and Medicare certification.

Medicare-certified facilities are registered as active providers for the dates of service. Other providers who qualify for this waiver are registered for 30 days. If a provider must provide services to an AHCCCS recipient for more than 30 days, the provider must complete the full registration process, unless there are extenuating circumstances.

GENERAL INFORMATION (CONT.)

Providers may register under either of two reimbursement types:

☑ Fee-for-service providers may bill the AHCCCS Administration for services provided to recipients who are not enrolled with an AHCCCS-contracted health plan or program contractor.

- ✓ Fee-for-service providers also may subcontract with health plans and/or program contractors to provide services to enrolled recipients.
- ✓ Services provided to an enrolled recipient are reimbursed by the recipient's plan.

☑ Encounter-only providers may only provide services to a recipient under a subcontract with a health plan or program contractor.

- ✓ Certain provider types are restricted to encounter-only providers.
- ✓ Encounter-only providers cannot submit fee-for-service claims to the AHCCCS Administration.

All AHCCCS providers are registered under a provider type (e.g., hospital, nursing facility, physician, etc.) established by AHCCCS. The AHCCCS Provider Registration Unit will help providers identify the most appropriate provider type, based on the provider's license/certification and other documentation.

Within each provider type, mandatory and optional categories of service (COS) are identified.

☑ Mandatory COS are defined by mandatory license or certification requirements.

- ✓ The provider must submit documentation of license and/or certification for each mandatory COS.

☑ Optional COS are those that the provider may be qualified to provide and chooses to provide.

- ✓ Optional COS which do not require additional license and/or certification are automatically posted to the provider's file.
- ✓ Optional COS which do require license/certification are posted once proof of current, valid licensure and/or certification is received.

Mandatory and optional COS, licensure/certification requirements, and the applicable procedure codes for each provider type are listed in the Provider Profile. Providers may be limited to certain procedures within a COS. If limitations are applicable, the allowable procedures are identified in the Provider Profile.

DOCUMENTS REQUIRED FOR REGISTRATION

The following documents must be completed, signed by the appropriate parties, and on file with the Provider Registration Unit before an AHCCCS provider ID number can be issued:

☑ Provider Registration Application Form

- ✓ This form must be completed in its entirety and signed by the provider, administrator, CEO, or owner.

☑ Provider Agreement

- ✓ The Provider Agreement is a contractual arrangement between the AHCCCS Administration and the provider.
- ✓ The agreement's form and content are consistent with Medicaid regulations, and no changes may be made to the language of the agreement.
- ✓ By signing the agreement, the provider indicates the following:
  - ☒ The provider has read the document in its entirety,
  - ☒ The provider understands all the terms of the agreement, and
  - ☒ The provider agrees to all of the stipulations in the agreement.
- ✓ Any provider who violates the terms of the agreement is subject to penalties and sanctions.
- ✓ The Provider Agreement remains in effect until terminated by either the AHCCCS Administration or the provider.
- ✓ The agreement for long term care facilities must be renewed annually, concurrent with the expiration date (survey date) for Medicare/Medicaid recertification.
- ✓ This agreement is required of all providers, including one-time only providers.

☑ Proof of licensure and certification

- ✓ Each provider must meet licensure/certification requirements applicable to its provider type as required by the professional licensing and certification boards or entities and as specified by federal and state statutes and regulations.
- ✓ Documentation of all licenses and certifications must be provided.
- ✓ An out-of-state provider must hold current, valid certification/license in the provider's own state.

☑ Form W-9: Request for Taxpayer Identification Number and Certification

GROUP BILLING

Any organization wishing to act as the financial representative for any provider or group of providers who have authorized this arrangement may register as a group billing provider. Group billers may not provide services or bill as the service provider.

Each service provider using the group billing arrangement must register as an AHCCCS provider and must sign a group billing authorization form. The authorization form is available from the AHCCCS Provider Registration Unit. The service provider's AHCCCS provider ID number must appear on each claim, even though a group billing number may be used for payment.

Each provider remains affiliated with the authorized group until the provider furnishes written notification to Provider Registration indicating termination of the group billing arrangement.

If a provider has multiple locations, the provider may be affiliated with multiple group billing associations.

The following examples illustrate how claims would be processed and reimbursed in specific situations:

Example:

Provider 111111-01 is in private practice and also works as a contract physician for a hospital. The hospital service provider ID# is 020000-01 and the hospital group billing ID# is 600000-01.

For services the provider furnishes in his/her private practice:

> Provider ID# 111111-01 is entered in the PIN# section of Field 33 of the CMS 1500 claim form. The GRP# section of Field 33 will be blank. Reimbursement is sent to the physician's pay-to address.

For services the provider furnishes under contract to the hospital for which the hospital bills:

> Provider ID# 111111-01 is entered in the PIN# section. The hospital billing ID 600000-01 is entered in the GRP# section. Reimbursement is made to the hospital’s group biller pay-to address.

CORRESPONDENCE, PAY-TO, AND SERVICE ADDRESSES

AHCCCS maintains a correspondence address, a pay-to address or addresses, and a service address or addresses for each provider except group billers. For group billers, AHCCCS maintains a correspondence address and a pay-to address.

☑ The *correspondence address* is the address where billing instructions, letters, and all other correspondence, except checks, are mailed.

- ✓ Each provider has only one correspondence address.
  - ☒ Even if a provider has multiple service addresses, the provider has only one correspondence address.
  - ☒ A provider must indicate the address where the provider wishes correspondence to be sent regardless of the service address(es).
- ✓ If the provider changes practices, partnerships, or place of practice and does not change the correspondence address, new correspondence will not be directed to the correct address.

☑ The *pay-to address* is the address on the reimbursement check from AHCCCS.

- ✓ The Remittance Advice, along with the reimbursement check, are mailed to the provider's pay-to address, as determined by the provider's tax identification number (See next page).

☑ The *service address* is the business location where the provider sees patients or otherwise provides services.

- ✓ A locator code (01, 02, 03, etc.) is assigned to each service address.
- ✓ As new service addresses are reported to AHCCCS, additional locator codes are assigned.
- ✓ When a service address is no longer valid, the provider must notify AHCCCS, and that service address locator code will be end dated.

TAX IDENTIFICATION NUMBER

A provider's tax identification number determines the address to which payment is sent. AHCCCS requires providers to enter their tax identification number on all fee-for-service claims submitted to the AHCCCS Administration.

Previously, a provider's two-digit service address locator code (01, 02, 03, etc.) was linked to one or more pay-to addresses. The locator code determined the address to which payment was sent. Providers should continue to append the service address locator code to their AHCCCS provider ID number to indicate the location where a service was performed. However, using the locator code will no longer direct payment to a specific address.

Providers must enter the appropriate tax ID on the claim form to direct payment to the correct address. If no tax ID is on file, the AHCCCS system will deny the claim because it will be unable to direct payment to a specific address.

If a provider's record shows more than one address linked to a tax ID number, the system will direct payment and the Remittance Advice to the first address with that tax ID number.

Providers who want reimbursement checks directed to more than one address must establish a separate tax ID for each pay-to address.

Providers who have questions about tax ID information on file with AHCCCS should contact the AHCCCS Provider Registration Unit.

LICENSURE/CERTIFICATION UPDATES

Each provider must meet licensure/certification requirements applicable to its provider type as required by the professional licensing and certification boards or entities and as specified by federal and state statutes and regulations.

AHCCCS systematically sends a letter requesting a renewed license/certificate to a provider's license/certification board or agency (except the Arizona Medical Board, formerly BOMEX) prior to expiration of the provider's license.

If a response is not received from the board or agency within 45 days, a request for a copy of a renewed license/certificate is sent directly to the provider. If the provider does not provide a copy of current license/certification within 21 days of the notification, the provider's active status will be terminated.

CHANGES TO INFORMATION ON FILE

It is the provider's responsibility to notify Provider Registration in writing of any changes to the information on file at AHCCCS. Failure to report changes may result in misdirected payments and correspondence and could result in the termination of the provider's active status or recoupment of payment.

All changes to information on file must be signed by the provider or the provider's authorized agent.

Changes that must be reported include, but are not limited to, changes affecting:

- ☑ Licensure/certification
  - ✓ A copy of the licensure or certification document should accompany notification.
- ☑ Addresses (correspondence, pay-to, and/or service)
  - ✓ Change of address forms are available from the Provider Registration Unit.
  - ✓ When a provider changes an address, a letter is sent to the provider for verification.
  - ✓ If the address information on the verification letter is incorrect, the provider should indicate the necessary changes, sign the letter, and return it to the Provider Registration Unit.
  - ✓ If the address information on the verification letter is correct, the provider need not respond.
- ☑ Name
  - ✓ A letter advising AHCCCS of the name change and supporting documentation (marriage license, divorce decree, or a copy of the provider's current license) is required.
  - ✓ A new Provider Agreement must be signed under the new name.
- ☑ Group billing arrangements
- ☑ Ownership
  - ✓ Provider Registration will mail the provider a new registration packet.
  - ✓ The provider must complete a new Provider Agreement and Provider Registration Form and submit new licenses and/or certification.
  - ✓ When all information is received from the appropriate agencies, Provider Registration will assign a new provider ID.

PHYSICIAN/MID-LEVEL PRACTITIONER REGISTRATION

Hospitals and clinics may not bill AHCCCS or the plans for physician and mid-level practitioner services using the hospital or clinic AHCCCS ID number. Physicians and mid-level practitioners must register with AHCCCS and bill for services under their individual AHCCCS provider ID number.

Mid-level practitioners include:

- ☑ Physician assistants
- ☑ Registered nurse practitioners
- ☑ Certified nurse-midwives
- ☑ Certified registered nurse anesthetists (CRNAs)
- ☑ Surgical first assistants

Note: Physician assistants, certified nurse-midwives, and nurse practitioners are reimbursed at 90 per cent of the AHCCCS capped fee or billed charges, whichever is less. Surgical first assistants are reimbursed at 70 per cent of the AHCCCS capped fee or billed charges, whichever is less. CRNAs are reimbursed at 100 per cent of the AHCCCS capped fee or billed charges, whichever is less.

Hospitals and clinics may register as group billers and bill as an agent for physicians and mid-level practitioners. In these cases, the claims submitted to AHCCCS must include *both* the physician's/mid-level practitioner's ID as the service provider and the hospital's/clinic's group billing ID number.

MEDICAL RECORDS

As a condition of participation, a provider must maintain and make available all records and information including, but not limited to, medical and financial records, relating to the AHCCCS program. Such records shall be provided at no cost to the AHCCCS Administration.

The recipient's medical records must be maintained in a current, detailed, organized, and comprehensive manner that permits effective review. Records must be legible and reflect all aspects of care, including ancillary services.

TERMINATIONS

There are several reasons a provider's participation in the AHCCCS program may be terminated.

☑ Voluntary termination

- ✓ A provider may voluntarily terminate participation in the program by providing 30 days written notice to:

AHCCCS Provider Registration Unit
MD 8100
P.O. Box 25520
Phoenix, AZ 85002

☑ Loss of contact

- ✓ AHCCCS may terminate a provider's participation due to loss of contact with the provider.
- ✓ Contact is considered to be lost if mail is returned as undeliverable by the Postal Service.
- ✓ Providers must inform the Provider Registration Unit of any address changes to avoid misdirected or lost mail and possible termination of the provider's active status.

☑ Inactivity

- ✓ Provider participation may be terminated if the provider does not submit a claim to the AHCCCS Administration or one of the AHCCCS-contracted health plans or program contractors within a 24-month period.

☑ Termination for cause

- ✓ The AHCCCS Administration has the right to terminate participation in the program by providing 24 hours written notice when it is determined that the health or welfare of a recipient is endangered; that the provider fails to comply with federal and state laws and regulations; or there is a cancellation, termination, or material modification in the provider's qualifications to provide services.

TERMINATIONS (CONT.)

☑ Termination for cause (Cont.)

- ✓ Any provider determined to have committed fraud or abuse related to AHCCCS or ALTCS or the Medicaid program in other states may be terminated or denied participation.
  - ☒ This provision is also extended to providers terminated from Medicare participation.
- ✓ Providers who are determined to be rendering substandard care to AHCCCS or ALTCS recipients may be terminated, suspended, or placed on restrictions or review.
  - ☒ Restrictions may be placed on the scope of services, service areas, health plan participation, or other limitations related to quality of care.
- ✓ If the provider's mandatory license or certification is revoked, suspended or lapses, the provider's participation may be terminated or suspended.

SANCTIONS

Providers may be sanctioned by AHCCCS for violations of the terms of the Provider Agreement. Sanctions may be imposed due to fraudulent or abusive conduct on the part of the provider. The decision to sanction will be based on the seriousness of the offense, extent of the violation, and prior violation history.

AHCCCS may impose any one or any combination of the following sanctions against a provider who has been determined to have abused AHCCCS or ALTCS programs:

☑ Recoupment of overpayment

☑ Review of claims (prepayment or postpayment)

☑ Filing complaint with licensing/certifying boards or agencies or with local, state or federal agencies

☑ Peer review

☑ Restrictions (e.g., restricted to certain procedure codes)

☑ Suspension or termination of provider participation

SANCTIONS (CONT.)

AHCCCS may impose any one or a combination of the following sanctions against a registered provider who has been determined to be guilty of fraud or convicted of a crime related to the provider's participation in Medicare, Medicaid, AHCCCS, or ALTCS programs:

- ☑ Recoupment of overpayment
- ☑ Suspension of provider participation
- ☑ Termination of provider participation
- ☑ Civil monetary penalty
- ☑ Criminal prosecution

NOTICE OF ADVERSE ACTION

The Provider Registration Unit will provide written notice of termination or suspension to providers which will include the effective date, the reason, and the provider's grievance rights.

- ☑ Actions based on fraud or abuse convictions are effective on the date of the conviction.
- ☑ Actions due to revocation, suspensions, or lapse of license or certification are effective the date that the license or certification becomes invalid.
- ☑ Actions due to the quality or appropriateness of care provided are effective on the date specified by the AHCCCS Office of Special Programs.
- ☑ All other adverse actions are effective 15 calendar days from the date of notification.

For adverse actions requiring 15 calendar days notice, the provider may submit evidence to Provider Registration disputing the action within 15 calendar days of the date of the notice. Provider Registration will review all documentation received by the first workday following the expiration of the 15-day notice period.

If Provider Registration confirms that the provider is eligible to participate, a notice will be sent to the provider verifying that no action will be taken to terminate participation.

Providers may grieve any adverse action including termination, suspension, and restriction (See Chapter 28, Claim Disputes).